

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006629

STATE FILE NUMBER

FILED FEB 25 1959

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 26

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Missouri</u> b. COUNTY: <u>Phelps</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps Co. Memorial</u>			Length of stay in lb <u>6 hrs.</u>		d. STREET ADDRESS (If outside, give location) <u>406 Onk st.,</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u></u> Last <u>LOSAYA</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18,</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1959</u>		9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (City and state or country) <u>Rolla, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Adam Losaya</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Blawrenser</u>			14. NAME OF HUSBAND OR WIFE <u>- - - - -</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Adam Losaya 406 Onk st., Rolla, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>(Lived 4 hours)</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>Birth</u> to <u>death</u> and last saw ^{her} / _{him} alive on <u>2-18-59</u> Death occurred at <u>4:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>E. E. Ferrell M.D.</u>				22b. ADDRESS <u>Rolla Mo.</u>		22c. DATE SIGNED <u>2-19-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rolla Cemetery</u>		23d. LOCATION (City, town, or county) <u>Rolla, Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Carl J. Glenn 1100 Elm, Rolla, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Feb. 20, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>			

Not Embalmed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.